		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024745

Facility Name: WINNING WHEELS

Address: 701 E. THIRD STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5168 **Fax #** 815-537-5268

IDPA ID Number: 237136038001

Date of Initial License for Current Owners: 01/01/79

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501 C(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) ALAN GAPINSKI

(Title) CEO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,530	2,372	477	6,379	8
9	SNF/PED					9
10	ICF	21,539		23	21,562	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,069	2,372	500	27,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.69%

D. How many bed-hold days during this year were paid by Public Aid?
768 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/79

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	173,232	15,090	5,337	193,659	2,067	195,726		195,726			1
2	Food Purchase		179,703		179,703		179,703	(2,812)	176,891			2
3	Housekeeping	59,128	26,607		85,735	794	86,529		86,529			3
4	Laundry	71,642	16,376		88,018		88,018	(21,000)	67,018			4
5	Heat and Other Utilities			103,815	103,815		103,815	(6,573)	97,242			5
6	Maintenance	75,823	51,152	44,647	171,622		171,622		171,622			6
7	Other (specify):*											7
8	TOTAL General Services	379,825	288,928	153,799	822,552	2,861	825,413	(30,385)	795,028			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	1,034,237	202,456	12,366	1,249,059	(19,972)	1,229,087		1,229,087			10
10a	Therapy	113,682	4,233	19,133	137,048		137,048		137,048			10a
11	Activities	75,760	17,952	1,148	94,860		94,860		94,860			11
12	Social Services	62,680			62,680		62,680		62,680			12
13	Nurse Aide Training					30,056	30,056	(16,754)	13,302			13
14	Program Transportation	14,863	16,209		31,072	(20,114)	10,958		10,958			14
15	Other (specify):* SPEECH/COGN	64,783			64,783		64,783		64,783			15
16	TOTAL Health Care and Programs	1,366,005	240,850	55,147	1,662,002	(10,030)	1,651,972	(16,754)	1,635,218			16
	C. General Administration											
17	Administrative			180,500	180,500		180,500	(56,380)	124,120			17
18	Directors Fees											18
19	Professional Services			38,363	38,363		38,363	1,294	39,657			19
20	Dues, Fees, Subscriptions & Promotions			31,469	31,469		31,469	885	32,354			20
21	Clerical & General Office Expenses	160,057		58,605	218,662		218,662	4,292	222,954			21
22	Employee Benefits & Payroll Taxes			331,377	331,377	(8,425)	322,952	31,654	354,606			22
23	Inservice Training & Education			9,939	9,939	(4,520)	5,419		5,419			23
24	Travel and Seminar			20,074	20,074		20,074	1,150	21,224			24
25	Other Admin. Staff Transportation		21,705		21,705		21,705	889	22,594			25
26	Insurance-Prop.Liab.Malpractice			21,907	21,907		21,907		21,907			26
27	Other (specify):*											27
28	TOTAL General Administration	160,057	21,705	692,234	873,996	(12,945)	861,051	(16,216)	844,835			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,905,887	551,483	901,180	3,358,550	(20,114)	3,338,436	(63,355)	3,275,081			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINNING WHEELS #0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			166,991	166,991	(8,544)	158,447	38,873	197,320			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,684	40,684		40,684	(38,552)	2,132			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			207,675	207,675	(8,544)	199,131	321	199,452			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					28,658	28,658		28,658			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,352	44,352		44,352		44,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			44,352	44,352	28,658	73,010		73,010			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,905,887	551,483	1,153,207	3,610,577		3,610,577	(63,034)	3,547,543			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,812)	10		4
5	Telephone, TV & Radio in Resident Rooms	(6,573)	13		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(21,000)	12		8
9	Non-Straightline Depreciation	33,912	30		9
10	Interest and Other Investment Income	(38,750)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	(16,754)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,595)	21&24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,572)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	762	30	33
34	Adjustments for Related Organization Costs (Schedule VII)	(11,819)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (11,057)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (69,629)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$ 28,658		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 28,658		47

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,812)	0	0	0	0	0	0	0	0	0	0	(2,812)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(21,000)	0	0	0	0	0	0	0	0	0	0	(21,000)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(23,812)	0	0	0	0	0	0	0	0	0	0	(23,812)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(23,327)	0	0	0	0	0	0	0	0	0	0	(23,327)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(23,327)	0	0	0	0	0	0	0	0	0	0	(23,327)	16
	C. General Administration													
17	Administrative	0	0	54,088	70,032	(180,500)	0	0	0	0	0	0	(56,380)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,294	0	0	0	0	0	0	0	0	1,294	19
20	Fees, Subscriptions & Promotions	0	0	529	356	0	0	0	0	0	0	0	885	20
21	Clerical & General Office Expenses	0	0	4,292	0	0	0	0	0	0	0	0	4,292	21
22	Employee Benefits & Payroll Taxes	0	13,733	17,921	0	0	0	0	0	0	0	0	31,654	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,150	0	0	0	0	0	0	0	0	1,150	24
25	Other Admin. Staff Transportation	0	0	889	0	0	0	0	0	0	0	0	889	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	13,733	80,163	70,388	(180,500)	0	0	0	0	0	0	(16,216)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,139)	13,733	80,163	70,388	(180,500)	0	0	0	0	0	0	(63,355)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number WINNING WHEELS **#** 0024745 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	34,674	0	2,613	1,586	0	0	0	0	0	0	0	38,873	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,750)	0	198	0	0	0	0	0	0	0	0	(38,552)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,076)	0	2,811	1,586	0	0	0	0	0	0	0	321	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(51,215)	13,733	82,974	71,974	(180,500)	0	0	0	0	0	0	(63,034)	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES, INC	0.00%	BIG MEADOWS, INC.	SAVANNA	LYNDON PROGRESS		DAY TREATMENT
	0.00%	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATION
WINNING WHEELS, INC.	100.00%	STRIVE	PROPHETSTOWN	LYNDON PLAY &		
				LEARN CENTER	LYNDON	CHILD DAY CARE
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		DAY CARE BENEFITS	$ 12,734	LYNDON PLAY & LEARN	100.00%	$ 26,467	$ 13,733	1
2	V								2
3	V		PROFESSIONAL SERVICES	180,500	AMERICAN HEALTH ENTERPRISES		154,948	(25,552)	3
4	V				MANAGEMENT COMPANY				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 193,234			$ 181,415	$ * (11,819)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.								$		1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT								2
3	(100% OWNER - AHE, INC)										3
4								MANAGEMENT			4
5	WINNING WHEELS, INC			0.00	36,512	18	36.00	FEES	180,500	17,3	5
6	S.T.R.I.V.E.			0.00	10,142	5	10.00	"	93,500		6
7	BIG MEADOWS, INC.			100.00	28,398	14	28.00	"	123,547		7
8	PLEASANT VIEW			100.00	20,285	10	20.00	"	84,533		8
9	OTHERS (NON-COST REPORTING)				6,085	3	6.00	"	84,000		9
10											10
11											11
12				TOTAL							12
13								TOTAL	$ 566,080		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AMERICAN HEALTH ENTERPRISES, INC.
Street Address: 501 6TH AVE. WEST
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3683)
Fax Number: (815-778-4503)

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 54,088	$ 54,088	1	$ 54,088	1
2	17	ADMINISTRATIVE	GROSS REVENUE	10,183,200	5	214,152	214,152	3,330,100	70,032	2
3	19	DATA PROCESSING	GROSS REVENUE	10,183,200	5	3,958	0	3,330,100	1,294	3
4	20	DUES AND SUBSCRIPTIONS	GROSS REVENUE	10,183,200	5	1,618	0	3,330,100	529	4
5	20	RECRUITMENT	GROSS REVENUE	10,183,200	5	1,090	0	3,330,100	356	5
6	21	SUPPLIES, PHONE	GROSS REVENUE	10,183,200	5	13,125	0	3,330,100	4,292	6
7	22	BENEFITS	DIRECT & INDIRECT	429,478	5	71,623	0	107,461	17,921	7
8	24	TRAINING & SEMINARS	GROSS REVENUE	10,183,200	5	3,517	0	3,330,100	1,150	8
9	25	ADNIM. TRANSPORTATION	GROSS REVENUE	10,183,200	5	2,717	0	3,330,100	889	9
10	30	DEPR'N VEHICLES	GROSS REVENUE	10,183,200	5	7,990	0	3,330,100	2,613	10
11	30	DEPR'N EQUIPMENT	GROSS REVENUE	10,183,200	5	4,849	0	3,330,100	1,586	11
12	32	INTEREST (VEHICLES)	GROSS REVENUE	10,183,200	5	606	0	3,330,100	198	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 379,333	$ 268,240		$ 154,948	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FARMERS NATIONAL BANK		X	MORTGAGE	$10,000.00	10/13/00	$ 750,000	$ 703,719	04/15/02	7.3500	$ 40,684	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,000.00		$ 750,000	$ 703,719			$ 40,684	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 750,000	$ 703,719			$ 40,684	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINNING WHEELS COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0024745

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: ?????? B. General Construction Type: Exterior MASONARY Frame CONCRETE BLOCK Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING SITE	504,424	1973	$ 23,500	1
2					2
3	TOTALS	504,424		$ 23,500	3

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1979	$ 1,526,858	$ 16,983	VARIOUS	$ 50,895	$ 33,912	$ 1,250,725	4
5			1979	1979	22,848		5	762	762	19,112	5
6			1979	1979	3,826		20			3,826	6
7			1985	1979	4,226	211	20	211		3,439	7
8			1987	1979	11,212	561	20	561		8,175	8
	Improvement Type**										
9	SEE DETAIL ATTACHED				456,925	24,972	VARIOUS	24,972		256,804	9
10	CARPET DIETARY AND MAIN			1997	415	83	5	83		387	10
11	COMPRESSOR FOR AIR CONDITIONER			1997	6,500	650	10	650		2,979	11
12	LAYING BRICK			1997	768	38	20	38		176	12
13	GARAGE DOOR			1997	667	33	20	33		153	13
14	GARBAGE DISPOSAL			1997	950	63	15	63		290	14
15	CARPETING			1997	2,255	226	5	226		1,842	15
16	PAINTING			1997	1,948	195	10	195		893	16
17	TILING			1997	18,869	943	20	943		4,324	17
18	LANDSCAPING			1997	1,480	148	10	148		678	18
19	SOFFIT			1997	4,495	225	20	225		824	19
20	BLACKTOP			1997	8,260	551	15	551		2,524	20
21	FAUCETS			1997	738	49	15	49		225	21
22	SOFFIT ADDITION			1998	952	48	20	48		194	22
23	COMPRESSOR FOR AIR CONDITIONER			1998	10,811	1,081	10	1,081		3,874	23
24	DINING ROOM IMP-GLASS			1998	973	49	20	49		183	24
25	FOLDING ROOM WALLS/DOORS			1998	5,099	255	20	255		892	25
26	FLOORING			1998	2,642	264	10	264		947	26
27	ALARM INSTALLATION			1998	952	95	10	95		341	27
28	CABINETS			1998	7,745	387	20	387		1,291	28
29	AIR CONDITIONERS 3.5 TON			1999	1,257	126	10	126		387	29
30	NATURE TRAIL LANDSCAPING			1999	18,965	1,897	10	1,897		5,057	30
31	PAINTING HALLWAY			1999	1,285	129	10	129		343	31
32	DUMPSTERS PAD AND FENCING			1999	1,873	375	5	375		968	32
33	POLYVINL FENCING 328FT			1999	2,375	119	20	119		267	33
34	GAZEBO			1999	8,200	410	20	410		923	34
35	FLOORING			1999	5,553	555	10	555		1,203	35
36	TOTAL (LINES 4-35)										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REMODEL DINING ROOM	1999	$ 6,724	$ 672	10	$ 672	$	$ 1,457	37
38	ABOVE GROUND PETROLEUM TANKS	1999	14,566	1,457	10	1,457		3,156	38
39	LANDSCAPING	1999	6,091	870	7	870		1,885	39
40	SECURITY SYSTEM UPGRADE	1999	5,472	782	7	782		1,629	40
41	GAZEBO INSTALLATION	1999	1,998	100	20	100		208	41
42	FRONT LIGHT FIXTURES	2000	4,507	451	10	451		676	42
43	STORM WATER PUMP	2000	2,404	343	7	343		515	43
44	PARKING LOT	2000	13,819	1,382	10	1,382		2,073	44
45	KITCHEN AND DINING AREA ROOF	2000	41,800	2,787	15	2,787		4,412	45
46	BREAKROOM FLOORING	2000	1,293	185	7	185		277	46
47	BUG BLOWER	2000	1,265	127	10	127		190	47
48	CARPET MULTI-SENSORY ROOM	2001	4,597	919	5	919		919	48
49	MULTI-SENSORY ROOM	2001	14,966	316	40	316		316	49
50	INDEPENDENT WAY GARDEN	2001	34,023	1,134	20	1,134		1,134	50
51	THERAPY ANNEX	2001	1,046,330	17,660	40	17,660		17,660	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,341,779	$ 80,903		$ 115,578	$ 34,674	$ 1,610,755	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 490,820	$ 54,670	$ 54,670	$	VARIOUS	$ 275,193	71
72	Current Year Purchases	106,131	8,787	8,787		VARIOUS	8,787	72
73	Fully Depreciated Assets	385,818					385,818	73
74	RELATED ORGANIZATION			1,586	1,586			74
75	TOTALS	$ 982,769	$ 63,457	$ 65,043	$ 1,586		$ 669,799	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORTATI	VARIOUS	VARIOUS	$ 170,621	$ 15,510	$ 15,510	$		$ 117,959	76
77	SNOW REMOVAL	93 DODGE	1993	20,645	2,065	2,065			17,376	77
78	BUS	95 FORD	1996	37,812	3,781	3,781			22,057	78
79	RELATED ORGANIZATION					2,613	2,613			79
80	TOTALS			$ 229,078	$ 21,356	$ 23,969	$ 2,613		$ 157,392	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,577,125	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 165,716	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 204,590	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 38,873	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,437,946	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	96

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	48

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		30	240	1,170	1,440
3	Classroom Wages	(a)	374	5,990		6,364
4	Clinical Wages	(b)		2,995		2,995
5	In-House Trainer Wages	(c)	337	2,696	13,144	16,177
6	Transportation					
7	Contractual Payments		27	213	1,040	1,280
8	Nurse Aide Competency Tests			400	1,400	1,800
9	TOTALS		$ 768	$ 12,534	$ 16,754	$ 30,056
10	SUM OF line 9, col. 1 and 2	(e)	$ 13,302			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 6,624

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	28
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	11
TOTAL TRAINED	48

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 421,514	$ 607,512	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	530,073	805,422	3
4	Supply Inventory (priced at)	44,107	58,088	4
5	Short-Term Investments	1,871,059	3,108,893	5
6	Prepaid Insurance	6,909	10,304	6
7	Other Prepaid Expenses	2,891	4,957	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	282,974	137,842	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,159,527	$ 4,733,018	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	84,615	13
14	Buildings, at Historical Cost	3,325,304	4,318,003	14
15	Leasehold Improvements, at Historical Cost		107,843	15
16	Equipment, at Historical Cost	1,211,846	1,714,209	16
17	Accumulated Depreciation (book methods)	(2,420,102)	(3,055,027)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCT PROGRESS	17,475	33,042	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,158,023	$ 3,202,685	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,317,550	$ 7,935,703	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,737	$ 74,992	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	93,898	93,897	29
30	Accrued Salaries Payable	77,058	109,474	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,884	14,064	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED	1,415,047	49,028	36
37	STRIVE REVENUE BOND		17,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,664,624	$ 358,455	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	609,822	609,822	40
41	Bonds Payable		196,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 609,822	$ 805,822	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,274,446	$ 1,164,277	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,043,104	$ 6,771,426	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,317,550	$ 7,935,703	48

*(See instructions.)

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,261,086	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,261,086	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(32,310)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) SUBSIDIARY COMPANIES		15
16	Other (describe) NET INCOME	542,650	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 510,340	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,771,426	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,006,233	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,994,233	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	15,071	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,812	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	21,000	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 38,883	23
	D. Non-Operating Revenue		
24	Contributions	456,757	24
25	Interest and Other Investment Income***	38,750	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 495,507	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	49,644	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 49,644	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,578,267	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	822,552	31
32	Health Care	1,662,002	32
33	General Administration	873,996	33
	B. Capital Expense		
34	Ownership	207,675	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	44,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,610,577	40
41	**Income before Income Taxes (line 30 minus line 40)****	(32,310)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (32,310)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,236	2,336	$ 43,130	$ 18.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,718	10,345	179,094	17.31	3
4	Licensed Practical Nurses	9,950	10,726	164,729	15.36	4
5	Nurse Aides & Orderlies	58,595	61,040	583,595	9.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,728	1,908	24,008	12.58	9
10	Activity Assistants	4,617	4,895	54,357	11.10	10
11	Social Service Workers	5,024	5,040	61,442	12.19	11
12	Dietician					12
13	Food Service Supervisor	1,715	1,804	26,856	14.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,317	21,331	145,841	6.84	15
16	Dishwashers					16
17	Maintenance Workers	7,984	8,736	75,674	8.66	17
18	Housekeepers	7,850	8,314	58,565	7.04	18
19	Laundry	10,118	10,886	71,617	6.58	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,485	14,639	159,154	10.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,928	2,096	20,756	9.90	31
32	Other Health Care(specify)	15,709	17,077	237,069	13.88	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,974	181,173	$ 1,905,887 *	$ 10.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	107	$ 5,337		35
36	Medical Director	225	22,500		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	55	2,200		39
40	Physical Therapy Consultant	27	1,360		40
41	Occupational Therapy Consultant	42	1,875		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	341	13,620		43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	RECREATIONAL THERAPY	23	1,148		47
48	PSYCHOLOGICAL THERAPY	22	2,175		48
49	TOTAL (lines 35 - 48)	842	$ 50,215		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 180,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 180,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LINDGREN, CALLIHAN	AUDIT	$ 8,575
WARD MURRAY PACE	LEGAL	2,574
HEYL,ROYSTER,VOELKER	LEGAL	150
OLIVE LLP	FINANCIAL	6,000
BK APPRAISAL	APPRAISAL	1,500
POLARIS	MEDICARE CONSULTANT	7,866
ESSEX	INTERNET SERVICES	240
MIDWEST	TIME SYSTEM MAINT.	2,260
ACHIEVE	SOFTWARE MANIT.	3,090
UNISOF	DIETARY SUPPORT	1,134
CREATIVE SOLUTIONS	MEDICAL RECORDS	3,442
COMPUTER INTEGRATION	WEBB SITE HOSTING	1,532
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 38,363

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,408
Unemployment Compensation Insurance	160
FICA Taxes	141,443
Employee Health Insurance	38,414
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	6,130
RETIREMENT	11,205
DISABILITY INSURANCE	13,824
PHYSICALS	3,303
CHILD CARE	29,324
OTHER	26,474
HOME OFFICE ALLOCATION	17,921
TOTAL (agree to Schedule V, line 22, col.8)	$ 354,606

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,952
Health Care Worker Background Check	
(Indicate # of checks performed 75)	750
I.H.C.A.	3,055
CARF	2,400
OTHER DUES,FEES,BOOKS	1,917
SUBSCRIPTIONS & DUES	7,395
HOME OFFICE DUES	529
HOME OFFICE RECRUITMENT	356
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,354

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,973
In-State Travel	17,101
HOME OFFICE ALLOCATION	1,150
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,224

**See instructions.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/00 Ending: 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,674** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **44,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **2,812**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **49,644**
c. What percent of all travel expense relates to transportation of nurses and patients? **100 %**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **LINDGREN, CALLIHAN, VANOSDOL, CPA LTI** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.